Health Related Services

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THE FACT that health-related services is a topic at this symposium is tangible evidence that among those concerned with health there is recognition of the fundamental kinship of health services and those services more commonly regarded as social or economic in purpose. This is a long step forward toward the time when the health and welfare of a human being and of the public of which he is an integral part will be literally indivisible.

This is not to deny that there are sicknesses of the body and mind that arise from physical causes accidental to or inherent in the environment. To trace and correct these causes is the traditional concern of public health personnel. However, sicknesses arising from social situations created by an uncongenial environment are more prevalent than ever before and have little direct relationship to the traditional focus of public health service. If we endorse the premise that the community's level of health can only be accurately measured by rating the level of health of each of its members, then the correction of socially induced illnesses becomes a logical matter for the attention of those developing or administering public health programs.

If this premise is sound, the real questions are how and through whom these economically and socially induced illnesses can be discovered and corrected. Since the basic unit of our work is the human being, the general current thinking (but not current practice) suggests that treatment of the whole man is essential to the attainment of desired results or their nearest approximation, according to the means at our command.

It is perhaps trite to comment that the complexity of organized society, and the rapidity by which that complexity is constantly being compounded, is often at the root of the individual's difficulties. It is even more trite to point out that well-directed and well-balanced teamwork is required if the interrelationship of these services and interests is to be demonstrated.

The team which comes into existence through our accepting the concept of a close relationship between social and health services consists of health and socioeconomically trained personnel, and, incidentally, the individual and his family. The task of the professional members of that team is to bring together as best they can the skills of the participants whose specialties have been splintered from the originally comprehensive and central core of treatment.

With the growing number of specialties in health and health-related fields, it is no longer possible for one person to be equally well versed in all of them. But it is possible to be aware of the potential that resides in their combination for preventive and better patient care and for public health. Without merging skills, the potential is obscured or lost.

In our day, it is the chronic or long-term illness or invalidism induced by such illness, with its health, social, and economic ramifications, that professional medical personnel are called upon to diagnose, understand, and treat. This may call for further specialization, but, if

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others are to understand his results, it also calls for an "ungrooving" of the specialist.

The Health-Related Fields

In the broadest sense, anything that enables an individual to maintain a satisfactory level of health may be considered health related. It is advisable at this point, however, to limit discussion to economic and social services that are quite obviously health related and that can be readily integrated with those personal and family health maintenance programs that form the true basis for the public health of the community.

Counseling and group work, employment after retirement, housing, and community organization are vitally important health-related services, but two important factors underlie all of them in our approach to better public health.

One of these is education of the public, especially through adult education, without which forward movement in each specific service would probably have been much slower than it has been.

The other is our country's means of providing income through employment and through its social security system. Private and government enterprise seeks to enable the individual by means of his own resources to assume the responsibility of his own health and his family's, even through the lean years of retirement.

Social Security Programs

Conditions of employment, including the wage level of the general population, play a distinct role in maintaining the health of workers and their families. These conditions are tempered by the degree to which workers appreciate their health needs since for many health is a strictly personal matter. This is another way of saying that money without understanding of how it can best be used is not enough.

It is increasingly apparent that management and labor are sensitive to the impact of working conditions upon the health of workers, over and beyond the safety measures that are admittedly health related. The growing concern about industrial health and about plans for services to reduce the costly inroads made by chronic illness on productivity indicates the direct relationship between jobs and economic and individual health.

This concern is most practically expressed in the partnership of government, business, and industry in the Nation's social security programs. These undeniably provide the most effective bulwark we have in maintaining the health of workers and retirees. The achievements by 1957 of the past generation in social security can be looked upon with justifiable satisfaction, even pride, by everyone. The interdependence of privately and publicly supported programs of economic and social security and public health programs does not require elaboration, although voluntary agencies may overlook at times the fact that their selectivity is possible only because the public services are in operation.

It has been said that the public assistance program is one of the best means of finding cases of acute or chronic illness. This is probably true of both the disability and the old-age and survivors' insurance phases of social security, although their lack of direct social service may make casefinding a somewhat minor component of the program.

The beneficiaries of these services have as a rule low or marginal incomes. A large majority of them are middle-aged or older people, and they are ready victims of illness. Until there is a closer working relationship between security programs and community health services (both voluntary and public), we shall not realize with sufficient understanding that for children and older adults inadequate living and health facilities are sources of the increasing incidence of chronic ailments. The income of the older adults usually fails to provide proper housing, decent environment, proper nutrition, or adequate medical care when and as needed. It may be truthfully said, however, that more is done in providing medical treatment than in underwriting the other factors that might help to prevent the present, extensive need for treatment.

The results of huge expenditures of scientific effort and funds for the development of the

Salk vaccine were dramatic; it would be wonderful if there could be an equally dramatic demonstration of what similar amounts of money and scientific effort might do to prevent or minimize the high incidence of malnutrition. Thousands of malnourished children and older adults are susceptible to acute or chronic disease, but exist on assistance grants and insurance benefits that, with all the will and skill to spend wisely, are just not enough to encompass their health needs.

With the new national public assistance grants that permit some States to take advantage of funds to provide more adequate medical care for recipients of public assistance, there will be spotty improvement. But with low levels of basic assistance in many areas, little more will be accomplished than ex post facto treatment. Strong bodies that resist more readily the inroads of acute or chronic illness will not be built. The program, moreover, will not help the beneficiary of social insurance whose funds are sufficient to make him ineligible for even consultation regarding his health needs, but are insufficient to enable him to pay for proper care. What is vital in all this is the growing opportunity and necessity for teamwork among the arms of public services at every level of government and among official agencies and voluntary social and health services at the local level.

Money, or the lack of it, is only one factor in the health situation. Hence the Public Health Service's development of the Chronic Disease Program offers a service of tremendous value that public and voluntary social agencies should promptly seize upon. The present possibility of educating the public about the known causes of illness, the effects of untreated illness, and the wisdom of taking advantage of the vastly improved knowledge of illness is without past parallel in most communities. It is a matter of record that lectures and discussions that attract the largest number of adult listeners and interested participants pertain to health and the prevention or treatment of illness. Matters of income maintenance run a close second. The necessity of learning to protect health and income is engaging more of the time, efforts, and funds of private persons and organized groups than ever before.

Individuals and social agencies, however, need a better understanding of health and illness and the effect of the latter on their work. Health agencies have a similar need to understand the meaning of individual attitudes and family culture and their impact upon physical and mental health.

Informal and formal groups offer an unusual opportunity for the dissemination of health information; the phenomenal growth of adult education programs should be taken advantage of without delay.

Counseling, Casework, and Group Work

In recent years the direct personal relationship between an individual and the social worker whose primary concern is the well-being of that individual has also gone through some changes. It is now divided into two phases: counseling and casework. This development seems to imply that counseling is either the threshold for casework or a rather diluted form of the intensive process that characterizes casework. Whether or not this is an accurate analysis, we find more and more people, particularly the middle-aged and older people, seeking "counseling" on health matters in all kinds of service agencies. Much more must be done in training and in the development of mutual understanding between health and social services if such counseling is to be sound.

Group work, in social service, helps people adjust to each other by coming to grips with their needs as they are modified or aggravated by the needs of others and by obtaining individual satisfaction through group action. With older people, this phase of social work is used extensively, with varying success, in "golden age" clubs and in day centers.

In counseling, casework, and group work it is essential to know the person as he is in a variety of settings and relationships (as a family member, worker, and citizen at large), and as he thinks he is. There can be a real difference between the two.

Of all the settings, the most important is the home; for here attitudes about health as about other matters originate. As living becomes more and more complex, as the firmness of family ties yields to some of the stresses and

strains created by this complexity, some glimmer of understanding of these attitudes becomes an essential component of health and social security programs.

If as one delegate to a governmental session forcefully commented, "Try to get a doctor to go to the home of an old chronic! It's pure nonsense to talk about it. Doctors just don't and won't go!" If this is true, whatever the reasons, doctors must come to depend on teamwork with social workers and public health nurses. For their success in working with people derives from a clear and sometimes intimate acquaintance with physical, psychological, and economic conditions in the home.

Today the public health nurse is the professional person most frequently visiting the home of chronically ill people. Generally, she is the one who is most welcome because of her easily understood and readily accepted service. If ways can be found to use her special skills at the outset of counseling, casework, or group work, we are more certain to find, as we have in the agency with which I am connected, that as health problems are minimized or resolved social situations have a way of being resolved or of resolving themselves more quickly.

Much has been said and written on the preventive aspects of group work in clubs and day centers with older people. Perhaps some of these claims can be substantiated. Experience, however, cogently indicates that professionally directed clubs and centers are seriously handicapped and limited unless they have direct ties with counseling, casework, or health services. The handicap stems usually from the need for help on physical and mental health problems; the staff is often unable to advise these people or to refer them correctly.

All this seems to point to the necessity for a greater emphasis on the physical and mental health aspects of social work, particularly in the family and group work agencies, and a greater emphasis on the social aspects of health work for health personnel.

As some of us watch service programs for older people, of whom many are handicapped by chronic illness or invalidism or are likely candidates for similar handicaps, the need for a working liaison between the branches of "comprehensive care" is distinctly highlighted. With the current shortages of trained personnel in all fields of service, probably the most we can expect or ask for is that the desirability of such teamwork be recognized through the appointment of consultants from the field of health in social agencies and from social services in health agencies.

Postretirement Employment

If we consider postretirement employment desirable, we must find some way of making employers and employees aware of the working conditions that are conducive to maintaining health at a level necessary to meet the requirements of the daily job. We must also learn more about an individual's health potential so that we may look for positive possibilities of employment. If it is a fact that we are reaching our later years in better health than our fathers or their fathers did, let us hope that health personnel can help us capitalize on this fact through the employment of older and retired workers.

There is at present a vague, but probably not baseless, notion that with better financial underpinning of retirement, older persons are less apprehensive about it and more willing to accept it, especially if retirement has been planned for. But we have a long way to go before retirement is fully welcomed and an equally long way to go before it is sufficiently underwritten to overcome the need many older people have of working mainly for the money they can earn, regardless of psychological or social motivation.

Society must also cope with the "right to work" at any age, for the worker's sake and perhaps for the sake of society as a whole. This topic is so controversial I shall only comment that any employment program for the elderly must be closely allied with a constantly watchful health program of prevention, treatment, and restoration. The last of these has not so far been as readily available to older people, either workers or nonworkers, as actual circumstances warrant.

Whereas older people are exceptionally vulnerable to the consequences of acute disease, we are finding they are also capable of an encouraging degree of restoration if given the benefit

of rehabilitation. Hence an unbiased partnership among management, labor, employment counselors, and health agencies assumes high priority for employment practices in the period currently designated as "retirement years."

Housing

Where and how people live unquestionably helps to determine the status of health they can maintain. The public health services have long been engaged in evaluating the sanitation and environmental factors which adversely affect health. Their concern not only for those facilities designed to house special health services but for housing accommodations in which people live assumes greater validity as more people, especially the chronically ill, continue to remain at home when sick.

If we take only the fact that about 95 out of 100 older people live in their own homes, either alone or in families, and relate that to the fact that the proportion of persons limited by chronic ailments is higher in the upper age brackets, it is not difficult to estimate the importance of any program of home health care and the attention that must be paid to the appropriateness of the home itself.

Whereas good family relationships are fundamental to propriety, the actual physical accommodations and their proximity to available services should be given equal consideration, whether the housing is under private, quasi-public, or public auspices. Principles of architectural design such as public health agencies propose for health facilities to reduce hazards and to be useful even for those with orthopedic handicaps may be applicable to private housing.

Certainly, in any large multiple dwelling as well as in individual homes accommodations that enable the chronically ill to remain at home have economic and social values that appear to merit serious thought.

The advice and help of health personnel are, or should be, an integral factor in such planning. As we look ahead to more extensive public housing programs for the elderly this becomes self-evident. But most conferences bog down on questions relating to the services and kinds of living quarters that are desirable and functional for the elderly under changing health circumstances. It is not a question of what, or how much of what, should be included in proposed or future housing plans for adequately accommodating the sick or infirm; we are confronted with the immediate issue of what should be done for those who have lived in housing developments long enough to be now among the aged. The housing and the tenants have aged together.

Community Organization

As we consider the community in which the chronically ill live and realize how great the gap is between facilities, services, and our knowledge about who the chronically ill are and what their demands are, it is easy to become discouraged.

Yet there is a trend (and perhaps the needs of the chronically ill are partially responsible) which is quite encouraging. This is the movement for the gradual merger of health and welfare planning agencies. Citizens are showing greater interest as more and more families are faced with problems for the solution of which neither services nor facilities exist, to say nothing of funds.

In these community movements there is a new realization that no single group in the community can be exempt from participation in both planning and action. Management and labor and professional personnel from all governmental and voluntary agencies and disciplines, including the church, and interested laymen will all be involved since all are directly affected. There is still the troubling tendency to specialize in disease entities or in groups defined by age and other distinctive characteristics, but even in specialized agencies (for example, the heart associations and commissions for the aging and aged) there is an intense awareness of the need for being a part of the local, State, and national communitywide approaches to the prevention and control of chronic illness.

Another encouraging sign is the trend to bring together, at least as affiliates, the various institutional programs of diagnosis, treatment, and restoration that serve the chronically ill. It will be still more encouraging when social service agencies are more definitely coordinated with and are promoting this type of affiliation

whose major objective is better service to the individual. Ultimately these measures should improve the quality of care in institutions as well as in homes, when the home-care programs are expanded.

As one observes the changing purpose of hospitals and homes for the aged and the changes in the actual use of them (nursing homes, for example, are now established as a part of the community's medical care facilities), one has an almost overwhelming sense of the immensity of the task of community education and organization that lies ahead before we find the chronically ill patient in the right place at the right time.

Sincerely interested leadership promises a brighter future, especially if all the "relatives" of the health field join with it in order to work toward an earlier approximation of the goal of comprehensive health care.

Medical Research Expenditures in 1970

Expenditures for medical research in this country can and should be tripled to reach a billion dollars a year by 1970, a group of special consultants to the Secretary of Health, Education, and Welfare said in a recent report.

The special consultants, 10 prominent medical educators and industry research executives, were appointed in 1957 by the Secretary to advise him on long-term needs in medical research and medical education. Dr. Stanhope Bayne-Jones, formerly dean of Yale University School of Medicine, was chairman.

The consultants warn, however, that such an expansion of medical research will require a major increase in the number of physicians and other scientists—from 20,000 now to 45,000 in 1970. To make possible this increase in research staff and at the same time to provide a sufficient number of physicians to give adequate care to the expanding population, additional educational facilities will be needed, they indicate.

According to present estimates, there will be only 19,000 additional physicians and scientists for medical research during the next 12 years, 6,000 short of the estimated 25,000 additional workers needed, the report states.

The consultants believe that "it would not be in the public interest for the number of physicians in the Nation to fall below the ratio of 132 for 100,000 persons." This ratio has remained fairly constant over the past 30 years.

To maintain this ratio, they assert, would require construction of from 14 to 20 new medical schools at a cost of between $500 million and $1 billion. This expenditure for medical school construction would be on a much larger scale than has heretofore been contemplated.

As the consultants point out, however, even if these large funds are made available immediately, the ratio of physicians to population will fall before 1970 because of the usual lapse of 10 years from the time a school is planned until the first class is graduated.

If the Federal Government continues to provide about half of all funds for medical research, Federal expenditures would increase from $186 million in 1957 to approximately $500 million by 1970, the consultants estimate. Industry's share in 1970 would be more than $300 million, and contributions of private philanthropy would amount to $100 million.

Signs and Symptoms

A 2-day orientation course in atmospheric pollution presented by the University of North Carolina at Chapel Hill in cooperation with the North Carolina State Board of Health has kicked off the State's first clean air inventory. A 6-month statewide study will be carried out under a Public Health Service grant.

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New York State Health Commissioner Hilleboe last July asked the State Attorney General to bring legal proceedings against more than 700 hotels and camps that had not obtained permits to operate. Under the law, a sanitary permit is required for every "temporary residence" in the State.

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Almost 3,000 physically handicapped workers are employed by the Department of Health, Education, and Welfare, in a total payroll of 53,000.

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Dr. Leonard Greenberg, New York City's commissioner of air pollution control, urges city motorists to maintain vehicles so as to combat visible exhaust smokes. A leaflet on the subject, prepared by his office, can be obtained from the Department of Air Pollution Control, 15 Park Row, New York 38, N. Y.

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Two amendments to the New York public health law require that firms and institutions apply to the State health department for permits to deal in, or dispense, narcotics after July 1, 1958. Each licensee is required to pay a $25 fee, and to register biennially starting April 1, 1960. Hospitals, laboratories, and dispensaries must pay $10 fees and are also subject to biennial registration.

Highway accidents are gaining recognition as the principal cause of death and disability among migratory agricultural workers.

The Toledo, Ohio, Diocesan Council of Catholic Women has prepared and distributed a 2-page pamphlet in English and Spanish on safety suggestions, based on the new ICC regulations.

Migrant workers may operate their out-of-state registered motor vehicles in Maryland for extendable periods of 90 days provided they first obtain a permit from an office of the Maryland Department of Employment Security and conform with other requirements regulating the use of vehicles transporting seasonal farm labor, the distance between crop and destination (not to exceed 35 miles), and the insurance coverage of vehicles (minimum of $10,000–$20,000 PI and $5,000 PD).

Pennsylvania's transportation regulations, similar to the ICC's, require owners of out-of-state vehicles used to transport seasonal crop workers to obtain a special permit. Vehicles must also be officially inspected.

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An all-out program of home inspection by fire departments would cut fire deaths as much as 50 percent, according to Percy Bugbee, general manager of the National Fire Protection Association. There were 6,405 accidental deaths by fire in the United States during 1956.

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In 1900, according to the Health Information Foundation, nonwhite infants could expect to live 33 years. By 1955, their life expectancy increased to 63.2 years, still 7 years less than the average for whites.

More than 25,000 copies of the leaflet, Food Facts vs. Food Fallacies, have been distributed since it was prepared in April 1957 for the Department of Health, Education, and Welfare to warn against quackery in nutrition.

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Three demonstration projects in Indianapolis, Kansas City, and Cincinnati will show what can be done in the above municipalities for those with "personal adjustment problems which prevent them from maintaining employment." The Office of Vocational Rehabilitation is paying the bulk of expenses.

A project at the Indianapolis Goodwill Industries gives preference to physically disabled persons with emotional problems. Goodwill and the Indiana Mental Health Association will share $50,000 cost for the first year of a 3-year program.

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A series of publications on air pollution, poisoning, and library resources have been issued by the division of occupational health, Texas State Department of Health, in Austin. Their titles are:

Ordinances and Legislation Related to Air Pollution, OH–20, December 1957; Current Trends and Approach to Air Pollution Problems in Texas, OH-20A, January 1958; The Problems and Effects of Air Pollution, OH-20B, January 1958; Communities and Counties in Texas Where Accidents Involving Use and Transportation of Atomic Materials Might Occur, OH-25, April 1958.

Poison Control Centers: Recommended First Aid Measures, OH-24B, June 1958; Poison Control Centers Located in Texas, OH-24A, June 1958; Economic Poisons Currently Recommended by Texas Agricultural Extension Service, and Organisms Against Which Recommended, OH-6-1 (superseding OH-6), March 1958.

Important Economic Poisons, OH-5-1 (superseding OH-5), March 1958; Poison Control Centers: Toxicology Information, OH-24, April 1958; and Occupational Health Library, OH-19-1 (superseding OH-19), April 1958.